STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:	REVIEW OF AGGREGATE	)	
	MEASURABLE COST SAVINGS	)	
	DETERMINED BY DIRIGO	)	FILING COVER SHEET
	HEALTH FOR THE SECOND	)	
	ASSESSMENT YEAR	)	

DOCKET NO. INS-06-900

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Respectfully submitted,

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:	REVIEW OF AGGREGATE	)	
	MEASURABLE COST SAVINGS	)	REPLY BRIEF OF INTERVENOR
	DETERMINED BY DIRIGO	)	MAINE STATE CHAMBER
	HEALTH FOR THE SECOND	)	OF COMMERCE
	ASSESSMENT YEAR	)	

DOCKET NO. INS-06-900

Pursuant to the Order on Motions dated June 26, 2006, Intervenor Maine State Chamber of Commerce (the "Chamber"), by and through its attorneys, hereby submits its Reply Brief.

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I. INTRODUCTION.

On June 30, 2006, the Dirigo Health Agency ("DHA") filed a brief in support of the DHA Board's May 12, 2006 determination ("Board's Determination") and June 9, 2006 filing with the Superintendent ("Dirigo Filing") that there was approximately $41.7 million of "aggregate measurable cost savings" ("AMCS") pursuant to 24-A M.R.S.A. § 6913(1). In its brief, the DHA acknowledged the substantial flaws in its "savings" methodologies, yet made no real attempt to rebut the Chamber's arguments. Instead, the DHA suggested that the Superintendent must simply defer to the Board and blindly accept its factual and legal findings as reasonable.

In addition, on June 23, 2006, intervenor Consumers for Affordable Health Care ("CAHC") filed a brief in which it argued that Board's Determination was unreasonable because it used a median rate for growth when calculating so-called CMAD "savings." However, because the CAHC based its CMAD arguments upon documents that admittedly were not contained in the Dirigo Filing, and because these documents have been specifically excluded from this proceeding by Order of the Superintendent, the CAHC's CMAD arguments must be disregarded.[1]

II. ARGUMENTS.

A. The DHA Board's Decision Is Not Entitled To Deferential Review.

The question before the Superintendent is whether the $41.7 million of AMCS is "reasonably supported by the evidence in the record."[2] 24-A M.R.S.A. § 6913(1)(C). Citing to

[1] Because the CAHC's brief contains tables from the excluded documents, and because the brief otherwise regurgitates the excluded Mercer document, the Chamber contends that the entire CAHC brief itself must be excluded from the record before the Superintendent.

[2] The Chamber agrees with the DHA Board that the Superintendent's review necessarily includes whether or not a particular category of savings falls within the statute. DHA Brief, p. 4, fn 2. However, the Chamber disagrees that the Superintendent's review of these categories must be deferential. The Chamber's position regarding which

court decisions addressing a court's review of final agency action, the DHA improperly suggests that the Superintendent's role is limited to a deferential "arbitrary and capricious" standard of review, and that the "Superintendent may not substitute his judgment for that of the Board." DHA Brief, pp. 2-3. As explained below, the DHA's attempt to invoke deference must fail.

First, the plain language of Section 6913 requires the Superintendent to hold a hearing under the Maine Administrative Procedures Act ("MAPA") and determine whether the AMCS is "reasonably supported by the evidence in the record." 24-A M.R.S.A. § 6913(1)(C). Neither Section 6913 nor the applicable provisions of the MAPA governing agency hearings state that the DHA (or its Board) is entitled to deference before the Superintendent. Moreover, the statute does not specify that the Board's determination must be upheld unless it is arbitrary and capricious. Instead, the statute requires the Superintendent to hold a hearing under MAPA and then make a determination whether the DHA Board's AMCS is reasonably supported by the evidence. This indicates that the Superintendent's review is independent and meaningful, not deferential and cursory.

Second, the legislative history of Section 6913 also supports a significant and independent review. As originally enacted, Section 6913 left the determination of AMCS entirely to the DHA Board. Thus, a party disagreeing with the DHA Board's determination could seek judicial review, and the court would apply the deferential standard described in the DHA's brief. This construct, however, caused much concern with members of both the House and Senate, perhaps best exemplified by the following rhetorical question asked during debates over the amendments to the original Act:

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categories may be included in AMCS, as well as the proper interpretation of Section 6913, has been clearly set forth in Section III of the Chamber's Brief dated June 23, 2006.

> How can the agency [DHA] conduct an impartial hearing on whether there are savings if the Board knows that without awarding the agency savings, the Dirigo Health Plan will go under?

See Legis. Rec. S-1836 (1st Spec. Sess. 2005) (Statement of Sen. Andrews); Legis. Rec. H-1000 (1st Spec. Sess. 2005) (Statement of Rep. Lewin). In light of concerns with DHA's inherent partiality,[3] the Minority Report[4] shifted the entire responsibility of determining savings to the Superintendent, with no Board involvement whatsoever. In contrast, the Majority Report[5] in its original form placed responsibility for determining savings solely with the Board.

The Minority Report, of course, failed, as did the Majority Report in its original form. Instead, a compromise was struck, whereby both the Board and the Superintendent have an important role in determining savings. As one member of the House put it, the compromise "sets the determination of cost savings on an annual basis to the Superintendent of Insurance." See Legis. Rec. H-1005 (1st Spec. Sess. 2005) (statement of Rep. Perry discussing House Amendment "B" to Committee Amendment "A" to S.P. 555, L.D. 1577, Filing No. H-687) (emphasis added).

Thus, the Legislature intended that the Superintendent engage in independent and meaningful review of the Board's determination. The perfunctory, deferential review championed by the DHA would make the Legislature's amendment a nullity. Not only would it have the effect of reinstating the original format of the rejected Majority Report, it would simply provide for an additional, hollow and costly layer of review that would be no different than direct

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[3] In addition to the cited rhetorical question, the floor debate contains a number of statements expressing concern by members of both houses. See, e.g., Legis. Rec. H-998 (1st Spec. Sess. 2005) (statement of Rep. Lindell discussing the minority report and observing that the tax should not be implemented solely by a board of five individuals who are political appointees); Legis. Rec. H-1004 (1st Spec. Sess. 2005) (statement of Rep. Vaughan that "[w]e [the Legislature] want to make sure that there is savings in the system and we want to be able to double-check it. We don't just want a board of five to tell us that there is savings….").

[4] Committee Amendment "B" to S.P. 555, L.D. 1577, Filing No. S-360.

[5] Committee Amendment "A" to S.P. 555, L.D. 1577, Filing No. S-359.

review by the courts (the process provided for by the original statute that was amended). Certainly, this cannot be the what the Legislature intended when it amended the statute to allay concerns regarding the DHA's inherent partiality and its essentially unrestrained discretion to fund its activities. Indeed, why would the legislature have gone to the trouble of amending the statute to add the Superintendent's review if his role was intended to be exactly the same as a reviewing court? Such an interpretation leads to an absurd result. The Superintendent was specifically given a role in this process, and that role is the independent and meaningful review of the Board's savings determination; not a rubber stamp.

Third, the fact that the DHA Board has a significant incentive to plump up AMCS, standing alone, suggests that the Superintendent's review must be thorough and careful. Indeed, the DHA's primary means of funding -- its very existence -- depends upon the Board finding AMCS. This stands in stark contrast to the proceedings before other agencies, where the agency's interest is merely upholding the law, and it does not have a direct stake in the outcome (beyond, of course, even handed application of the laws, regulations and policies governed by the agency).

Fourth, although the DHA argues that the Chamber received a fair and impartial hearing, an objective, independent review of the record suggests otherwise. As described in the Chamber's principal brief, the proceeding below failed to comport with traditional notions of fairness and due process. Furthermore, as described in the other intervenor's briefs and reply briefs (which the Chamber incorporates herein by this reference) the Board's actions in this case do not portray impartiality. The record is littered with Board member comments adverse to the payor intervenor's interests, followed by blind admiration for the work product of the DHA.

Finally, the CAHC recently conceded that Mr. McCann, one of only three voting members of the Board, had a significant -- and undisclosed – bias/conflict of interest because he is a sitting member of the Board of Directors of intervenor CAHC (a party to this proceeding). Although the Superintendent cannot undo this bias/conflict of interest, or change the ultimate legal consequences flowing from it[6], he can carefully review the record, make up his own mind regarding the reasonableness of the evidence in the record, and insist that the DHA discharge its burden of proving that each category of AMCS is "reasonably supported by the evidence in the record." Blindly accepting the Board's factual findings, which were themselves the result of blinders and rose colored glasses, will only compound the existing failure of due process.

B. The DHA Board's New Interpretation Of AMCS Is Not Entitled To Deference And Is Not Reasonably Supported By The Evidence In The Dirigo Filing.

The DHA now suggests that AMCS is not limited by Section 6913, but instead relates to "saving initiatives that are identified or flow from the Dirigo legislation or other governmental initiatives." DHA Brief, p. 7. The sole basis for this expansive reading is an allegedly missing comma before and after the words "as a result of the operation of Dirigo Health." Id. Put differently, the DHA offers that the Superintendent should disregard (1) the plain language of the statute read as a whole; (2) the well established principle of ejusdem generis; and (3) extensive legislative history and the administration's own descriptions of the Dirigo program, all of which prove that the meaning of AMCS is limited to savings "as a result of the operation of Dirigo Health" and "any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." More importantly, the DHA would have the Superintendent ignore the DHA Board's cover letter to the Dirigo Filing in the first assessment year, which

[6] The Chamber contends that the Board's May 12, 2006 and June 6, 2006 determinations were legally defective because Mr. McCann should have affirmatively disclosed the conflict and recused himself, leaving only two voting members. 24-A M.R.S.A § 6904(6) (requiring an affirmative vote of 3 members for any action taken by the Board).

parsed Section 6913 in the exact manner that the DHA now says is impossible. It read: "The Act tasked the … [Dirigo Board] with annually determining the aggregate measurable cost savings as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in Maine eligibility." (emphasis added).

C. Hospital Savings Initiative (CMAD) "Savings" Are Not Reasonably Supported By The Evidence In The Dirigo Filing.

In its brief, the DHA argues that its CMAD methodology is reasonable, even though it concedes that

- there was no "express statutory request that hospitals limit growth in CMAD";
- the Maine Hospital Association voluntary cap of 4.5% "was not used in the methodology for CMAD;
- the methodology "captured savings from Dirigo and other factors";
- the CMAD methodology "incorporated random fluctuations";
- the methodology only produces savings by using "two years of historical growth rate projected forward"; and
- the methodology assumes "all cost savings accrue to the market."

DHA Brief, pp. 9-11.

Even assuming that an express statutory request that hospitals voluntarily limit growth in CMAD can form the basis for AMCS, the absence of a statutory basis for the Second Assessment Year provides conclusive proof that the Legislature did not intend to count such "savings" under Section 6913. Furthermore, the Chamber invites the Superintendent to review the pre-filed and live testimony of Mr. Michaud and decide for himself whether it is reasonable to attribute the MHA's activities to the operation of Dirigo Health. Mr. Michaud could not have been more clear that the MHA initiative had nothing to do with Dirigo savings, and that hospitals have employed cost cutting measures before the creation of Dirigo Health. **AR 11, pp. 5147-**

5151. Furthermore, the articles and press releases relied upon by the DHA during its cross examination came at a time when the MHA was working with the Hospital Study Commission to create voluntary targets for the third, fourth and fifth assessment years -- not the second.

Likewise, the record is clear that Mercer made no attempt to parse out Dirigo-related "savings." Mr. Schramm himself testified that the Board would be required to separate the Dirigo-related savings from those random fluctuations that naturally occurred both before and after the enactment of the Dirigo Health Act. **AR 11, pp. 5115-5118.** The Board declined to follow Mr. Schramm's instruction, leaving no reasonable basis for assuming that <u>all</u> of the "savings" produced by Mercer's CMAD methodology is Dirigo-related.

Furthermore, the Board has failed to provide a reasonable explanation for ignoring the 4.5% MHA target in its methodology, and the fact that a new and different target necessarily requires measurement from the immediately preceding year -- not two years' prior. Indeed, projecting out two years merely double counts "savings" that were already captured in the First Assessment Year. This is demonstrated by Mercer's own calculations, which show that the percentage increase in cost per CMAD for SFY 2005 (6.9%) exceeded the historical average (6.2%) as well as the MHA target (4.5%). **AR 10, p. 4687; AR 3, p. 1453.**

Moreover, the Board unreasonably assumed that all cost savings measured by its methodology "accrue to the market" notwithstanding (1) 5-10% of patients are uninsured (and they should get the benefit of savings); (2) MaineCare's (Medicaid) payment for outpatient services on a reasonable cost basis (**AR 10, pp. 4679-4680**); and (3) Mr. Brauner's -- the DHA's own expert -- concession that any cost savings for critical access hospitals ("CAH") would automatically pass through to the Medicare and Medicaid programs. **AR 11, p. 5105 (p. 53, ln 10 - p. 54, ln 10.** Because approximately 40% of hospitals in Maine are CAHs, and because

Medicare and Medicaid typically account for 50-60% of hospital utilization, the Board's determination is not reasonably supported by the evidence.

Similarly, the Board's decision to disregard the impact of Medicaid cuts on hospital costs per CMAD is unreasonable. The DHA did not dispute the Medicaid rates cut for SFY 2004 and 2005 -- or the fact that the effect of these cuts continue to this date. The cuts for SFY 2004 and 2005 were implemented by emergency rule on July 28, 2003, which is <u>after</u> the Dirigo Health Act was adopted. **AR 10, pp. 4672-4685.** However, whether or not these cuts were adopted prior to the enactment of the Health Reform Act, it is the <u>effect</u> of the cuts -- reduced revenue which must be addressed through cost cutting and charge increases -- that is relevant to the reasonableness of the Board's adopted methodology. It is undisputed that the effect of the cuts continued throughout SFY 2004 and 2005. Not coincidently, SFY 2004 and 2005 are the first two CMAD "savings" measurement periods. Therefore, it is unreasonable to assume that <u>all</u> cost cutting measures that occurred during SFY 2004 and 2005 were attributable solely to Dirigo Health when Medicaid significantly reduced its payments during this same time period. As set forth in **AR 9, pp. 4264-4265**, the MHA identified SFY 2004 and 2005 cuts as being in addition to the SFY 2003 cuts, and this document supports that hospitals cut their budgets to absorb these Medicaid cuts. Moreover, in response to a question from Mr. McCann, Mr. Michaud clearly stated that a hospital's response to Medicaid cuts includes both budget cuts and charge increases. **AR 11, p. 5151 (p. 85, ln 24 - p. 86, ln 2).** Certainly, the DHA provided no evidence that the hospitals magically undid these costs cutting measures in the face of the additional Medicaid cuts. Nevertheless, the Board unreasonably assumed that all cost cutting measures were solely related to Dirigo Health.

Moreover, the DHA argues that the methodology "incorporates the hospital tax since it is an allowable cost under Medicare that should flow through worksheet C of the MCRs." DHA Brief, p. 10. If the hospital tax is an allowable cost under Medicare, then it should not be removed from the expense portion of the CMAD calculation. However, that is exactly what the Mercer methodology does -- it removes the hospital tax from the calculation, creating the illusion of lower cost per CMAD. This is because a reduced expense amount is divided by the same number of discharges. The impact of offsetting the hospital tax is dramatic -- simply by replacing the hospital tax allocation offset of $47,706,721 on line 74 of the Mercer spreadsheet with $0 and recomputing the live spreadsheet, the "savings" declines by $47,706,721. **AR 10, p. 4709.** Because this would completely wipe out the "savings" determined by using the Board's median growth adjustment, the Superintendent must reject all CMAD savings as unreasonable.[7]

Finally, the DHA apparently agrees with the Board's assessment that the Mercer methodology is highly sensitive to small changes in volume, yet the DHA does nothing to explain the significantly different volume numbers identified in the Mercer calculations. Multiplying the number of discharges by the cost per CMAD should equal the "consolidated" hospital's total cost (less applicable offsets). However, this is not the case. <u>See</u> **AR 10, p. 4709** (multiplying 2005 Cost per CMAD (6,316) x Case Mix and Outpt adj discharges (344,711) = $2,177,194,676 which <u>exceeds</u> total expenses in Col. 1, ln 103 ($2,155,212,589); **AR 9, p. 4300.** (Mr. Mercier identifying the actual volume numbers used to calculated cost per CMAD). Since

[7] At the very least, the hospital tax allocation should be reported as a net number. Accordingly to the MaineCare program's own calculation, as well as testimony by Mr. Michaud, hospital lose money on the hospital tax and match program, that is, they pay approximately $5,390,182 more in taxes than they receive in enhanced Medicaid payment (match). **AR 9, p. 4056; AR 11, p. 5145 (p. 62, ln 4-7).** This would lower the CMAD savings by $5,390,182.

it is undisputed that small changes to volume can significantly influence the "savings" identified by the Mercer methodology, the Superintendent must reject the methodology as unreasonable.[8]

D. Uninsured Initiatives are Not Reasonably Supported by the Evidence in the Dirigo Filing.

As explained in the Chamber's principal brief, the Uninsured Initiatives contain numerous assumptions that are not reasonably supported by the evidence in the record. In its brief, the DHA admits that its calculations are not based upon available actual data showing a reduction in provider bad debt and charity care expense ("BD/CC"). Because the DHA failed to use the available actual data to measure reductions in BD/CC expense, and it failed to contradict any of the Chamber's arguments with respect to unsupported assumptions, the Superintendent must reject any savings related to the Uninsured Initiatives as not reasonably supported by the evidence in the record.

E. CON/CIF Initiatives are Not Reasonably Supported by the Evidence in the Dirigo Filing.

As explained in the Chamber's principal brief, the DHA failed to include necessary information in support of the alleged CON/CIF "savings." The DHA apparently realized its error, and filed a Motion for Leave to Present Additional Evidence in an attempt to plug the obvious evidentiary gaps.

The record is bereft of reasonable support for the Board's decision. Indeed, there is no documentary evidence in the record regarding the actual scope of the CON projects at issue or the reasons that the providers revised or abandoned them. Furthermore, neither Ms. Cobb nor Mr. Schramm provided specific evidence regarding the reasons for review or abandonment. Therefore, it is unreasonable to assume that these projects were revised or abandoned due to the

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[8] At the very least, the actual volume number (323,726) (**AR 9, p. 4300**) should be used as the multiplier against the per discharge "savings" ($43) (**AR 9, p. 4262**) to determine total CMAD "savings." This would result in "savings" of $13.9 million versus the DHA "savings" figure of $14.5 million.

operation of Dirigo Health -- or even new CON criteria adopted as part of the Dirigo legislation. Indeed, as Mr. Schramm testified, if a CON application was denied for a reason in the CON statute prior to Dirigo Health, it would <u>not</u> be "savings." **AR 11, p. 5046 (p. 294, ln 17-20).**

With respect to the CIF "savings," there is no evidence in the record that all of the projects would have been approved (or would have been approved) in accordance with the pre-Dirigo CON review criteria, all of which remain the law today. In fact, when questioned regarding whether two new hospitals would have been approved in Waterville, Ms. Cobb declined to answer. **AR 11, p. 5033-5034.** Accordingly, the Superintendent must reject any savings related to the CON/CIF initiatives as not reasonably supported by the evidence.

Furthermore, in its brief, the DHA concedes that the alleged CON/CIF "savings" will occur, if at all, several years in the future, and that the costs (or absence thereof) will be reflected in the CMAD calculation. DHA Brief, pp. 14-15. Nevertheless, the DHA insists that it may count future unrealized "savings" now, and vaguely suggests that it will somehow account for these "savings" in future CMAD calculations. This approach must be rejected as unreasonable.

F. Health Care Provider Fee Initiatives are Not Reasonably Supported by the Evidence in the Dirigo Filing.

(1) <u>PIP Increases</u>.

At the hearing, the DHA witness Mr. Greene conceded that the PIP increases do not represent higher MaineCare payment rates (representing new money to the system), but instead simply represent payment of an existing obligation less slowly than before. **AR 11, p. 5052 (p. 319, ln 2-7).** A PIP increase does not affect revenue because the entire MaineCare receivable (the difference between PIP and the actual amount due) is already booked as revenue in the year the services are provided. **AR 9, p. 5.** Instead, a PIP increase provides an incremental benefit to cash flow. Therefore, the slightly higher -- but still inadequate -- incremental weekly payments offer the opportunity for "cost savings" only if a hospital can use the increased cash flow to pay down an interest bearing debt, thereby avoiding the future payment of interest expense. However, the DHA offered no evidence that all hospitals have actually incurred an interest obligation which can be discharged by funneling the incremental weekly amount to pay off an existing debt.

Furthermore, even assuming that a hospital does in fact use the incremental weekly increase to pay down debt, the interest expense avoided can only be counted once, that is, during the year in which the debt is retired. For example, even if the Superintendent assumes that hospitals owed the full amount of the alleged PIP increase on their respective lines of credit ($48,100,039) with an interest rate of 4.30%, the total amount of interest expense that these hospitals would incur for 2006 would be $2,068,301 ($48,100,039 x 4.3%). Thus, even assuming that the $48,100,039 was paid in a lump sum at the beginning of the fiscal year (instead of weekly incremental amounts, as it is actually paid), the largest possible "cost savings" (avoided interest expense) would be just over $2,000,000. However, the "cost savings" adopted by the Board with respect to PIP -- $7,020,260 -- substantially exceeds this best case scenario. Such a finding is not reasonable.

Moreover, the DHA offered no evidence to support the estimated PIP increase for SFY 2007. The record is void of budgetary information identifying the alleged PIP increase. Mercer provided no source documentation for its assumption, and Mr. Greene, the DHA's witness, acknowledged that he had no documentary support for the alleged SFY 2007 PIP increases. Furthermore, Mr. Green conceded that the MaineCare program has not even issued hospital PIP letters for SFY 2007. **AR 11, pp. 5052 (p. 318, ln 20 - p. 319, ln 1).** Therefore, there is no evidence in the record that hospital will in fact receive increased PIP rates for the first half of

SFY 2007 (July 1, 2006 to December 31, 2006). In fact, the record is bare on the issue of whether hospitals have actually received the PIP increases for the second half of SFY 2006, or for that matter, whether hospitals had a balance on a line of credit which could be paid off if the PIP money was received. Without this necessary evidence, it is unreasonable to conclude that there are any savings for this time period.

Even if the Superintendent assumes that the undocumented and unspecified PIP increases will actually occur and all hospitals have drawn on a line of credit to improve cash flow, Mercer's calculations overstated the incremental increase in total hospital PIP from SFY 2006 to SFY 2007. Indeed, according to Mercer, SFY 2006 PIP was $330,366,878, compared to $350,661,028 for SFY 2007. **AR 3, p. 1463.** This represents an increase of only $20,294,150, not $58,246,114 as suggested by Mercer's calculations.[9] Accordingly, the total incremental increased PIP for 2006 is only $29,124,057 (one half of $37,953,964 plus one half of $20,294,150), leaving the best case scenario for avoided interest expense at $1,252,334 (again, assuming a lump sum payment on January 1, 2006). Of course, even this number must be substantially reduced to reflect the weekly incremental nature of the PIP increases.

Apparently, the DHA believes that the best case scenario should be tripled because it argues (without support) that the PIP payments are three years early. However, this argument assumes that the debt was not paid off, which is contrary to the basis for funding "savings" in the first place. But, even assuming that "savings" should be counted three times, this is just another example of the DHA manufacturing future "savings" and trying to count it now. Indeed, even assuming that the DHA can count avoided interest expense more than once, the additional two

[9] Apparently, Mercer assumes that PIP rates would never increase beyond the SFY 2005 level in the absence of Dirigo Health. Such an assumption is refuted by Mr. Greene's testimony that PIP is intended to be an estimate of a hospital's actual costs for the year. **AR 11, p. 5053 (p. 323, ln 2-15).**

years of future savings (if any), would not arise until calendar year 2007 and 2008, respectively.[10]

Because the DHA failed to provide evidence that the hospitals actually had an interest expense that could be relieved by higher incremental payments, the Superintendent should reject the methodology as not reasonably supported by the evidence in the record. Furthermore, it is important to note that any reduction to a hospital's interest expense will naturally be reflected in a hospital's cost per CMAD. Accordingly, if the increased PIP payments have resulted in a true cost savings, such savings are already captured in the CMAD methodology.

(2) Physician Fee Increase.

Although the DHA argues that there are "savings in the Health Care System" as a result of the Medicaid physician fee schedule increase, DHA Brief, p. 16, it makes no attempt to explain how increasing a physicians MaineCare revenue has relieved the physicians of a cost. Instead, the DHA suggests that physicians must now use the "new money" to reduce the need to "shift costs." Id. In other words, the DHA suggests that all physicians must now turn over the long awaited fee increase in the form of lower charges to commercial health carriers (even though lower charges do not result in lower payments by insurance carriers)[11], who must then turn over the "savings" to the DHA in the form of an SOP. As a result, the long awaited Medicaid fee increase is merely illusory.

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[10] It appears that the DHA has already counted some of the 2006 and 2007 "savings" during the first assessment year. Thus, in addition to counting multiple years of avoided interest expense in a single year, the DHA seeks to compound this error by counting three years every year.

[11] Interestingly, in the CMAD section, the DHA suggests (incorrectly of course) that Medicare and Medicaid would not benefit from hospital cost savings (notwithstanding reasonable cost based Medicaid hospital outpatient payment for all hospitals and reasonable cost based inpatient and outpatient Medicare and Medicaid reimbursement for CAHs). Despite uncontroverted testimony by Ms. Roberts of Anthem that most physicians are not reimbursed based upon charges or cost, the DHA now suggests (incorrectly of course) that reduced charges or costs will have the desired effect for the physician fee initiative.

Putting aside the phantom interest expense and the illusory fee increases, the most ironic point about the Provider Fee Initiatives methodology is that the $53 million of initial Dirigo Health funding was a one-time allocation of federal dollars designed to help States with their Medicaid budget problems. **AR 9, p. 4265.** It appears that the DHA was not satisfied with taking the $53 million out of the hands of the provider community. Now it wants to take $15 million more -- in addition to the $7.3 million that it took in the first assessment year. This is not reasonable.

III. CONCLUSION

For the reasons set forth above and identified in the Chamber's principal brief, the DHA Board's Determination is not reasonably supported by the evidence in the Dirigo Filing. Accordingly, the Superintendent must reject all alleged savings related to the Hospital Initiatives (CMAD), CON/CIF Initiatives, and Provider Fee Initiatives, and reduce the Uninsured Savings to an amount that is reasonably supported by the evidence in the record.

Dated: July 7, 2006

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CERTIFICATE OF SERVICE

I, William H. Stiles, attorney for the Maine State Chamber of Commerce, hereby certify that on this 7th day of July, 2006 the foregoing document was served on the following parties via first-class mail and electronic mail:

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